

# DEPRESSION

2001

Hensel, Carolyn; Sapp, Marty; Farrell, Walter; Hitchcock, Kim (2001). A Survey of members of ASCH, SCEH, and Division 30, and if they reported using hypnosis to treat depression. *Sleep and Hypnosis*, 3 (4), 152-166.

A telephone survey was conducted with randomly selected members of the American Society of Clinical Hypnosis (ASCH), the Society of Clinical and Experimental Hypnosis (SCEH), and the Psychological Hypnosis Division of the American Psychological Association (Division 30). The purpose of this study was to explore the extent to which hypnosis society members reported using hypnosis to treat major depression. A 3-group MANOVA did not find any differences among the groups, and all members reported using hypnosis to treat depression.

Yapko, Michael (2001). Hypnosis in treating symptoms and risk factors of major depression. *American Journal of Clinical Hypnosis*, 44 (2), 97-108.

This article summarizes aspects of effective psychotherapy for major depression and describes how hypnosis can further enhance therapeutic effectiveness. Hypnosis is helpful in reducing common symptoms of major depression such as agitation and rumination and thereby may decrease a client's sense of helplessness and hopelessness. Hypnosis is also effective in facilitating the learning of new skills, a core component of empirically supported treatments for major depression. The acquisition of such skills has also been shown to not only reduce depression, but also the likelihood of relapses, thus simultaneously addressing the issues of risk factors and prevention.

Yapko, Michael (2001, October). Hypnotic intervention for ambiguity as a depressive risk factor. *American Journal of Clinical Hypnosis*, Vol. 44 (No. 2), 109-118.

In the face of ambiguous life events, depressed individuals are more likely to make negative and depressing interpretations than nondepressed individuals. Fundamental to the success of cognitive-behavioral treatments, one of the most empirically supported treatments for depression is teaching the client to recognize and self-correct so-called cognitive distortions. To facilitate that learning process, clients can learn to better recognize and tolerate ambiguity inherent in many situations, and thereby diminish the drive to form subjective interpretations (either negative or positive) when more objective evidence is unavailable. This article describes ambiguity as a risk factor for depression and details a strategy employing hypnosis for teaching the skills of both recognizing and tolerating ambiguity.

Yapko, Michael (2001). *Treating depression with hypnosis: Integrating cognitive-behavioral and strategic approaches*. New York NY: Brunner-Routledge.

## NOTES

(From the cover) Focuses on structuring and delivering of hypnotic interventions for major depression, with a substantial use of concepts and techniques from cognitive-behavioral and strategic approaches as a foundation. Current research on depression is used to emphasize the still growing knowledge of depression. Hypnosis has shown itself to be effective in not only reducing symptoms, but in teaching the

skills (such as rational thinking, effective problem-solving and coping strategies, and positive relationship skills) that can prevent recurrences. (PsycINFO Database Record (c) 2002 APA, all rights reserved).

1998

Eimer, Bruce; Freeman, Arthur (1998). Pain management psychotherapy: A practical guide. New York NY: John Wiley & Sons, Inc..

#### NOTES

"Pain Management Psychotherapy" (PMP) provides a clear and methodical look at pain management psychotherapy beginning with the initial consultation and work-up of the patient and continuing through termination of treatment. It is a thoughtful and thorough presentation that covers methods for psychologically assessing the chronic pain patient (structured interviews, pain assessment tests and rating scales, instruments for evaluating beliefs, attitudes, pain behavior, disability, depression, anxiety, anger and alienation), treatment planning, cognitive-behavioral therapy techniques, and a range of hypnotic approaches to pain management. The book covers both traditional (cognitive and behavior therapy, biofeedback, assessing hypnotizability, choice of inductions, designing an individualized self-hypnosis exercise) as well as newer innovative techniques (e.g., EMDR, pain-relief imagery, hypno-projective methods, hypno-analytic reprocessing of pain-related negative experiences). An extensive appendix reproduces in their entirety numerous forms, rating scale, inventories, assessment instruments, and scripts. The senior author, Bruce Eimer, states in his online comments on Amazon.com that "most therapists hold the belief that 'real' chronic pain patients are quite impossible to help. This book attempts to dispel these misguided beliefs by providing a body of knowledge, theory, and techniques that have proven value in understanding and relieving chronic physical pain." He also states that "the challenge for the therapist is to persuade the would-ne patient/client that he or she has something to offer that can help take way pain and bring back more pleasure. This challenge is negotiated through the therapeutic relationship. However, the therapist just can't be 'warm, accepting, non-judgmental and empathic'. The therapist must also have knowledge and skills relevant to relieving pain. Only then can the therapist impart such knowledge, and in teaching these skills to the pain patient, help the patient become something of a 'self-therapist'. . . I dedicate this book to everyone who wants to find ways to make living with pain more comfortable, and to the ongoing search for better ways to relieve pain."

1995

Holroyd, Jean (1995). Handbook of clinical hypnosis, by Judith W. Rhue, Steven Jay Lynn, & Irving Kirsch (Eds.) [Review]. International Journal of Clinical and Experimental Hypnosis, 43 (4), 401-403.

#### NOTES

"This is a book for the thinking clinician" (p. 401). "The editors are to be congratulated for making this volume much more coherent than most edited books" (p. 402). "My impression is that the book is best suited for an intermediate or advanced course on hypnotherapy, or for people who are already using hypnosis in treatment. Although there is some material on the basics of hypnotic inductions and a few introductory sample scripts for inductions, a beginners" course should probably use a different book, or this book could be accompanied by an inductions manual. ... I recommend it very highly" (p. 403).

Wickramasekera, Ian (1995, November). Hypnotic ability, skin conductance, and chronic pain. [Paper] Presented at the annual meeting of the Society for Clinical and Experimental Hypnosis, San Antonio, TX.

## NOTES

T. X. Barber's book in 1969 states that hypnotizability is unrelated to psychopathology. Hilgard's book states that hypnotic ability and negative reactivity are unrelated. However clinicians working with somatization-type symptoms (headache, irritable bowel disease) may observe a surplus of people very high or low in hypnotic ability. How do we account for the discrepancy between clinic and lab? Is this a context effect, since I only see people who are sick? It turns out that the low hypnotizable patients present mainly in primary care, medicine and surgery. The highs present with psychophysiological problems.

The author posits that when hypnotic ability and negative affectivity coincide, they lead to physical disease. (He uses "negative affectivity" for what used to be called Neuroticism.) Negative affect is not simply verbal report; one must also consider autonomic physiology as part of it (cf.. Dan Weinberger's research).

Highs are at risk for illness because: 1. They can amplify or attenuate signals of threat. 2. They demonstrate surplus pattern recognition (see meaning in randomly distributed events). 3. They have surplus empathy (poor boundaries).

Lows are at risk because: 1. They deny or attenuate the role of cognitive and emotional events on somatic symptoms. 2. They demonstrate rigidity in information processing; they are locked into critical, sequential, analytical information processing.

Under low stress (mental math), Lows and Highs do not differ on Subjective Units of Distress (SUDS) for mental arithmetic; for high stress (more difficult math) there is a large difference between groups.

High, Medium, and Low hypnotizable Ss with chronic pain and no observable pathology (TMJ, back pain, etc.) were measured on skin conductance (EDR): there were no differences during baseline, but differences emerged during a stress condition. We did not find this kind of difference using muscle tension! Patients were not on medications. GSR is a purely sympathetic nervous system measure, unlike heart rate that also has parasympathetic input. There is almost a dose-response relationship between hypnotizability and reactivity with GSR under stress conditions.

High Hypnotizable and High Negative Emotion Subjects: EDR 12.5 SUDS 63.5 Lie Scale (Marlowe Crowne)

Moderate Hypnotizable and Low Negative Emotion Subjects: EDR 3.77 (p.<.01) SUDS 66.5 (n.s.) Lie Scale 20.7 (p.0001).

Thus, you could not see a difference in these two groups from their verbal report, their MMPI, or an interview. Their distress is out of mind [but not out of body].

We also studied Body Mass Index (weight related to height), which correlates highly with adiposity (Garrow, 1983). We used High Hypnotizable - High Neuroticism Subjects, compared to Medium Hypnotizable - Low Neuroticism Subjects. H-H BMI = 34.6 M-L BMI = 24.1 (significantly different, though preliminary results).

If you just use a correlation you won't see this result. You have to consider both hypnotizability and negative emotion together.

### COMMENTS FROM THE AUDIENCE:

Question re Marlowe Crowne as a measure of defense.

Wickramasekera's answer: I believe it is orthogonal to hypnotizability and both are pathways to pathology. I look at both the Marlowe Crowne and Neuroticism.

Auke Tellegen: In Weinberger's research you need to see an interaction between test variables. I think you should view them independently, not assume an interaction.

1994

Wickramasekera, Ian (1994, October). On the coincidence of two orthogonal risk factors for psychophysiological regulation and dysregulation: implications for somatization. [Paper] Presented at the annual meeting of the Society for Clinical and Experimental Hypnosis, San Francisco.

#### NOTES

People low or high in hypnotizability are at risk. Our article in the upcoming issue of the *Journal of Nervous and Mental Disease* will present this information. High hypnotizable people have either somatic symptoms or psychological symptoms; lows show primarily somatic symptoms. We found that 38% of highs and 28% of lows show somatic symptoms. The lows won't usually be found in a Mental Health Center; they are staying in primary care medical services.

Hypnotic ability and insomnia.

Insomnia was defined by EEG in 3 sleep studies (latency to stage 1 onset of EEG), and patients were screened to omit those with pathophysiology. We measured hypnotizability, finding 50% high on Harvard Scale, 40% low, with a small percent in the middle. [Thus the distribution is bi-modal.]

Neuroticism and insomnia (Wickram, Ware & Saxon, 1992). Neuroticism is the "negative affect" variable. Most people high on negative affect are high hypnotizables. Charcot was right [about high hypnotizables being neurotic] but he didn't have a measure of neuroticism. We are measuring negative affect.

#### PREDICTIONS

Low hypnotizables will show only or mainly somatic symptoms and be found in primary medical care or surgical settings. Highs will show a mix of somatic and psychological and somatic symptoms.

Most lows wouldn't sit still for the Harvard Scale, so we used the Absorption scale. We gave the Absorption scale to non-organic chest pain patients. Most had low scores on Absorption, followed by those with moderate scores, and fewest were highs on Absorption: 50% low, 36% moderate, 13% high.

Absorption scores in morbidly obese (350# or more) candidates for bypass surgery were: 55% are low on Absorption, 5% are high on Absorption.

People high on hypnotizability and on negative affectivity have greater risk for illness. See results of our research in *American Journal of Clinical Hypnosis*, a recent issue. These people are more psychophysiologicaly reactive, in heart rate, electrodermal reactivity, etc.

1992

Vijselaar Joost; Van der Hart, Onno (1992). The first report of hypnotic treatment of traumatic grief: A brief communication. *International Journal of Clinical and Experimental Hypnosis*, 40 (1), 1-6.

In 1813 the Dutch physicians Wolthers, Hendriksz, De Waal, and Bakker reported the hypnotic treatment of a woman suffering from traumatic grief, in which the therapist had to deal directly with the patient's spontaneous reenactments of the circumstances surrounding the death. This report, summarized in the present article, has historical value, as it is probably the first known precursor of the uncovering hypnotic approach. The original authors' views on the case are discussed, and a modern view for understanding the patient's traumatic grief and its treatment is presented.

1991

Cochrane, Gordon J. (1991). Client-therapist collaboration in the preparation of hypnosis interventions: Case illustrations. *American Journal of Clinical Hypnosis*, 33, 254-262.

Therapists can use hypnosis in a variety of situations to help clients utilize their own resources effectively. In both heterohypnosis and tape-assisted self-hypnosis, the respectful collaboration of therapist and client in the development of specific intervention strategies can be effective. I have described four cases to illustrate the collaborative aspect of heterohypnosis in a surgical setting and tape-assisted self-hypnosis for anxiety, tinnitus, and situational depression. In each case the clients were willing and able participants.

NOTES: "Hypnotic interventions as adjunctive therapeutic modalities for a variety of surgical procedures have been well documented (Frankel, 1987; Gravitz, 1988; Nathan, Morris, Goebel, & Blass, 1987). The availability, relative safety, dependability, and ease of use have made chemical agents the anesthetic of choice in the majority of surgical situations, but hypnosis, either alone or in conjunction with chemical agents, can have a number of advantages for some patients (Udolf, 1987, p. 248). Some patients who have extreme preoperative pain and anxiety can learn to use self-hypnosis (Frankel, 1987); others may use hypnosis when experiencing postoperative nausea and other uncomfortable side effects of chemical anesthetics. Some may fear death under general anesthesia or react to a previous trauma arising from general anesthesia and the operating room procedures in general (Udolf, 1987, p. 250) and therefore choose hypnotic strategies. In the following case illustration the patient feared general anesthesia because of a previous negative postoperative experience" (p. 255).

While collaboratively planned hypnosis often empowers the patient, contributing to a sense of personal control and well being, some patients are not able to participate in that manner. Cochrane cites patients who are severely depressed or "who struggle with narcissism and other severe pathologies" (p. 260). He notes that audiotapes are useful for supplementing in-session therapy, contributing to skill development, attitude change, and a sense of self-worth. He cites Eisen and Fromm (1983) as indicating that self hypnosis is also useful for clients "who struggle with issues of control and intimacy" (p. 260).

Terr, Lenore C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry*, 148, 10-20.

Suggests 4 characteristics common to most cases of childhood trauma: visualized or otherwise repeatedly perceived memories of the traumatic event; repetitive behaviors; trauma-specific fears; and changed attitudes about people, life, and the future. Childhood trauma is divided into 2 basic types. Type I trauma includes full, detailed memories, "omens," and misperceptions while Type II trauma includes denial and numbing, self-hypnosis and dissociation, and rage. Characteristics of both types of childhood trauma can exist side by side. Such crossover Type I - Type II traumatic conditions of childhood are characterized by perceptual mourning and depression and childhood disfigurement, disability, and pain. Case examples are provided.

Witz, Marylou; Kahn, Stephen (1991). Hypnosis and the treatment of Huntington's Disease. *American Journal of Clinical Hypnosis*, 34, 79-90.

Describes two cases treated with a wide variety of hypnotic interventions. One was treated for 9 years and the other for 10 sessions. Hypnotic techniques and daily self-hypnosis appeared to ameliorate both physical and psychological difficulties, thereby enhancing the quality of life that remained for the patients. They noted that the increased sense of control that both patients experienced seemed to undercut the cycle of physical symptoms exacerbating psychological symptoms and these in turn increasing physical symptoms. The sense of control over physical symptoms clearly reduced anxiety and depression over the inevitable course of the disease, thereby facilitating tension reduction and overall adjustment to

the disease. This reduced stress level may have in turn affected the disease itself. What is unmistakable is that the quality of life was greatly enhanced.

1990

Harmon, Teresa M.; Hynan, Michael T.; Tyre, Timothy E. (1990). Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education. *Journal of Consulting and Clinical Psychology*, 58, 525-530.

Studied the benefits of hypnotic analgesia as an adjunct to childbirth in 60 nulliparous women. Subjects were divided into high- and low-susceptibility groups before receiving six sessions of childbirth education and skill mastery using an ischemic pain task. Half of the subjects in each group received a hypnotic induction at the beginning of each session; the remaining control subjects received relaxation and breathing exercises typically used in childbirth education. Both hypnotic subjects and highly susceptible subjects reported reduced pain. Hypnotically prepared births had shorter Stage 1 labors, less medication, higher Apgar scores, and more frequent spontaneous deliveries than control subjects' births. Highly susceptible, hypnotically treated women had lower depression scores after birth than women in the other three groups. The authors believe that repeated skill mastery facilitated the effectiveness of hypnosis in the study.

Kaye, J. M.; Schindler, B. A. (1990). Hypnosis on a consultation-liaison service. *General Hospital Psychiatry*, 12, 379-383.

Studied the use of hypnosis on a consultation-liaison service with a broad spectrum of medically hospitalized patients. Autohypnosis tapes were used for reinforcement. Twenty-nine women and eight men from 24-75 years of age were hypnotized for relief of depression, pain, anxiety, or side effects of chemotherapy. Results were excellent (total to almost total relief of symptoms) in 68%, fair in 22%, and poor in 11%, with no differences among the results with the various conditions. This demonstrates that hypnotherapy is an extremely useful tool in medical management of patients in consultation-liaison psychiatry.

Martin, Maryanne (1990). On the induction of mood. *Clinical Psychology Review*, 10, 669-697.

## NOTES

Increasing interest in the relation between emotion and cognition has led to the development of a range of laboratory methods for inducing temporary mood states. Sixteen such techniques are reviewed and compared on a range of factors including success rate, the possibility of demand effects, the intensity of the induced mood, and the range of different moods that can be induced. Three different cognitive models (self- schema theory, semantic network theory, and fragmentation theory) which have been successfully used to describe long-term mood states, such as clinical depression, are elaborated to describe the process of temporary mood induction. Finally, the use of mood induction is contrasted with alternative methods (such as the study of patients suffering from depression) for investigating emotion.

Rokke, Paul D.; Carter, Alice S.; Rehm, Lynn P. (1990). Comparative credibility of current treatments for depression. *Psychotherapy*, 27, 235-242.

Current treatments of depression were evaluated for credibility. Interpersonal, communication, self-control, cognitive, social skills, and relaxation placebo therapies were rated significantly more credible and efficacious than psychodynamic and activity-change therapies, which were rated significantly more credible than biological (drug) therapy. Implications were addressed.

1989

Ross, Colin A.; Heber, S.; Norton, G. R.; Anderson, D.; Anderson, G.; Barchet, P. (1989). The Dissociative Disorders Interview Schedule: A structured interview. *Dissociation*, 2, 169-189.

The Dissociative Disorders Interview Schedule (DDIS), a structured interview, has been developed to make DSM-III diagnoses of the dissociative disorders, somatization disorder, major depressive episode, and borderline personality disorder. Additional items provide information about substance abuse, childhood physical and sexual abuse, and secondary features of multiple personality disorder. These items provide information useful in the differential diagnosis of dissociative disorders. The DDIS is published in this article. It has an overall interrater reliability of 0.68. For the Diagnosis of MPD it has a specificity and a sensitivity of 90%.

Spinhoven, Philip; Linssen, A. Corry (1989). Education and self-hypnosis in the management of low back pain: A component analysis. *British Journal of Clinical Psychology*, 28, 145-153.

Conducted a component analysis of a group program for chronic low back pain patients. 45 patients (aged 31-68 years) participated in the pain control course (PCC), consisting of education about pain and a training in self-hypnosis. A pain diary was used as a measure of pain intensity, up-time, and use of pain medication. Psychoneuroticism and depression were assessed using the Symptom Checklist-90 (SCL- 90) scores. No evidence was found for a differential efficacy of education or self-hypnosis on pain diary and SCL-90 scores. Subjects showed significant changes on all measures except reported pain intensity. It is suggested that the PCC is a noninvasive, inexpensive means of treatment that could be used to teach even more severely disabled low back pain patients to cope more adequately with their pain problem.

Van der Does, A. J.; Van Dyck, R. (1989). Does hypnosis contribute to the care of burn patients? Review of the evidence. *General Hospital Psychiatry*, 11, 119-124.

In burn treatment, hypnosis has been used for alleviation of pain, prevention and treatment of anxiety and depression, and acceleration of wound healing. Successful application of hypnosis decreases the extensive medication needed. Furthermore, it provides a tool to patients with which they may experience more control in situations that are often experienced as overwhelming. Notwithstanding these important applications and the very positive terms with which the results of studies are generally described, hypnosis has mostly been neglected as a tool to help burn patients. This article reviews the clinical and experimental evidence of the usefulness of hypnosis in the management of burns. Pain reduction and crisis intervention are promising applications. However, due to a lack of systematic and controlled research, more specific conclusions are precluded. In the controversial area of wound healing, claims for the effectiveness of hypnosis have been made on the basis of slim evidence and inconclusive studies. This hypothesis needs to be addressed in controlled experiments. In summary, systematic investigations are needed to confirm and supplement available clinical evidence. Recommendations for future research are given.

1988

Robins, Clive J. (1988). Development of experimental mood induction procedures for testing personality-event interaction models of depression. *Journal of Clinical Psychology*, 44 (6), 958-963.

Developed 2 mood induction procedures for use in testing personality- event interaction hypotheses with regard to the onset of depressed mood of clinical depression. In these inductions, Ss listened to audiotapes depicting either a series of social rejections or achievement failures and were instructed to imagine themselves as the main character. Both tapes were found to produce a strong increase in reported depressed affect in 119 normal undergraduates. These effects were large in comparison to those elicited by commonly used mood induction procedures. Women reported greater mood shifts than men in response to both tapes. It is concluded that the present procedures have the advantage of content specificity, which permits test of personality-event interaction hypotheses.

Spiegel, David; Hunt, Thurman; Dondershine, Harvey E. (1988). Dissociation and hypnotizability in posttraumatic stress disorder. *American Journal of Psychiatry*, 145 (3), 301-305.

The authors compared the hypnotizability of 65 Vietnam veteran patients with posttraumatic stress disorder (PTSD) to that of a normal control group and four patient samples using the Hypnotic Induction Profile. The patients with PTSD had significantly higher hypnotizability scores than patients with diagnoses of schizophrenia (N=23); major depression, bipolar disorder-depressed, and dysthymic disorder (N=56); and generalized anxiety disorder (N=18) and the control sample (N=83). This finding supports the hypothesis that dissociative phenomena are mobilized as defenses both during and after traumatic experiences. The literature suggests that spontaneous dissociation, imagery, and hypnotizability are important components of PTSD symptoms. (*Am J Psychiatry* 1988; 145:301-305)

1985

Silverman, Lloyd H. (1985). Research on psychoanalytic psychodynamic propositions. *Clinical Psychology Review*, 5 (3), 247-257.

Discusses a research program in which the present author has been involved that deals with the subliminal psychodynamic activation method. In this method, verbal and/or pictorial stimuli, some of which contain content related to unconscious wishes, fears, and fantasies and other of which are (relatively) neutral, are presented to Ss at 4-msec exposures. A variety of psychoanalytically based hypotheses have been tested on various clinical and nonclinical populations. Two major findings have emerged: (a) a number of clinical groups (e.g., schizophrenics, depressives, stutterers) have shown intensifications of their symptoms after the subliminal exposure of stimuli designed to stir up particular unconscious conflicts; and (b) various clinical and nonclinical groups have manifested enhanced adaptive behavior after the subliminal exposure of the message "Mommy and I are one," conceived as activating unconscious symbiotic fantasies.

1979

De L. Horne, David J.; Baillie, Jennifer (1979). Imagery differences between anxious and depressed patients. In Burrows, G. D.; Collison, D. R.; Dennerstein, L. (Ed.), *Hypnosis* 1979 (pp. 55-61). Amsterdam: Elsevier/North-Holland Biomedical Press.

## NOTES

"In conclusion, the topic of this study is as yet a very new area of research. No other studies were found which specifically tested the difference between anxious and depressed people in imagery and hypnotic susceptibility. There were a number of limitations to the present study, which further studies could avoid.

Larger samples could be used, and such variables as age, educational level and anxiety should be more carefully controlled. The type of depression, whether agitated or retarded, should be assessed, and level of arousal to the imagined scene measured more accurately, with for example, other physiological measures than the E.M.G. It would be preferable to test depressed people while they are not on medication. Though the effects of antidepressant drugs on imagery were not actually documented, it would seem very likely that significant effects could exist on the ability to image; these obviously warrant investigation" (p. 61).

1977

Novaco, Raymond W. (1977). Stress inoculation: A cognitive therapy for anger and its application to a case of depression. *Journal of Consulting and Clinical Psychology*, 45 (4), 600-8.

Clinical interventions for anger disorders have been scarcely addressed in both theory and research in psychotherapy. The continued development of a cognitive behavior therapy approach to anger management is presented along with the results of its application to a hospitalized depressive with severe anger problems. The treatment approach follows a procedure called "stress inoculation," which consists of three basic stages: cognitive preparation, skill acquisition and rehearsal, and application practice. The relationship between anger and depression is discussed.

1975

Spear, J. E. (1975). The utilization of non-drug induced altered states of consciousness in borderline recidivists. *American Journal of Clinical Hypnosis*, 18, 111-126.

Utilizing non-drug induced altered states of consciousness, various modes of interior reflection, behavior modification and reprogramming of conscious attitudes and values were utilized with 49 borderline recidivists. Such offenders were so determined by the Department of Corrections, Probation and Parole Office, District II. No coercion was used to induce such individuals to enter the program and there was no reprisal for stopping therapy at any time. Over a two and one-half year period the recidivist rate among this group was less than 5%. It is suggested that non-drug induced altered states of consciousness combined with indirect as well as symbolic techniques may prove to be the most effective means of criminal rehabilitation.

#### NOTES

Borderline recidivists were "individuals, who, in the opinion of the P.O. [probation officer] were, in all probability, to be returned to prison within a few months, or less, if there wasn't a major change in attitude and actions" (p. 111). Therapy employed closed circuit TV with bi-directional audio and induction of altered state of consciousness using an ophthalmology-type rotary prism. Therapy involved (s) recall of relaxed state when under stress, (2) exploration of early conditioning events, (3) self evaluation during the ASC, (4) use of symbolic mental exercises and mental practice for similar circumstances in normal waking state, (5) suggestions for setting goals and ideals, (7) a type of logotherapy, (7) 'nudging' the person to examine their relationship with their concept of God. The author noted in the parolees: (1) low levels of self esteem, (2) depression, (3) going into deep levels of altered states once trust was established with the therapist.

1972

Hodge, James R. (1972). Hypnosis as a deterrent to suicide. *American Journal of Clinical Hypnosis*, 15 (1), 20-24.

A method that has been found successful in temporarily deterring suicide attempts is to give the post-hypnotic suggestion that the patient will not be able to carry out an actual suicide attempt until he has discussed it with the psychiatrist, in advance of the attempt, and in the psychiatrist's office, and further, that the patient will agree to enter a trance at any time the psychiatrist insists, even though the patient may not wish to do so. The rationale for this approach is that, (a) A temporary deterrent is often all that is necessary to prevent a given suicide attempt, (b) Hypnosis can have only a temporary deterring effect on suicide, (c) A direct and permanent confrontation that he can never commit suicide would be bound to fail and would not promote therapy of the personality, and (d) It gives the patient an alternative to suicide.

1968

Chambers, Helen (1968). Oral eroticism revealed by hypnosis. *International Journal of Clinical and Experimental Hypnosis*, 16, 151-157.

A CASE STUDY OF THE OUTPATIENT TREATMENT OF A SEVERELY DEPRESSED WOMAN. THE CASE WAS COMPLICATED BY THE S'S REFUSING USUAL ANTIDEPRESSANT TREATMENTS. COMMUNICATION WAS DIFFICULT BUT WAS FINALLY ACHIEVED BY THE USE OF ETHER AT ALTERNATE INTERVIEWS. WITHDRAWAL OF ETHER WAS THEN USED TO CREATE A SITUATION OF DEPRIVATION TO AROUSE IN THE TRANSFERENCE ATTITUDE THE FEELINGS PRODUCED BY THE EARLY TRAUMA. THE S'S COMPULSION TO EAT RAW POTATOES WAS STUDIED WHILE SHE WAS DEEPLY HYPNOTIZED. PSYCHOANALYTIC THEORIES THAT PLACE THE ORIGIN OF DEPRESSION AT THE TIME WHEN THE ORAL PHASE IS PRIMARY WERE CONFIRMED. THE S REFUSED ANY OTHER ANTIDEPRESSANT TREATMENT. (GERMAN + SPANISH SUMMARIES) (PsycINFO Database)